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IN THE
Supreme Court of the United States

DAVID KING, ET AL.,
Petitioners,

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF *AMICI CURIAE* FOR BIPARTISAN ECONOMIC SCHOLARS IN SUPPORT OF RESPONDENTS

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CASES

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General Dynamics Land Systems, Inc. v. Cline, 540 U.S. 581 (2004) 5

Good Samaritan Hospital v. Shalala, 508 U.S. 402 32

Halbig v. Burwell, 758 F.3d 390 (D.C. Cir. 2014), *reh'g granted en banc, judgment vacated*, No. 14-5018, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014) 5, 30, 31

National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012) 6, 7, 8, 9

STATUTES

26 U.S.C. § 36B 9

26 U.S.C. § 5000A 8

26 U.S.C. § 5000A(e)(1)(A) 10

26 U.S.C. § 5000A(e)(1)(B)(ii) 10

42 U.S.C. § 300gg 7

42 U.S.C. § 300gg-3 7

42 U.S.C. § 300gg-4 7

42 U.S.C. § 300*ll*-2(a)(1) (2012) 31

42 U.S.C. § 300*ll*-5(c)(2)(b)(i)(III) (2012) 31

42 U.S.C. § 18032(c)(1) 11-12

42 U.S.C. § 18081 9

42 U.S.C. § 18082 9

42 U.S.C. § 18091(2)(D) 2, 6, 11

42 U.S.C. § 18091(2)(G) 23

42 U.S.C. § 18091(2)(I) 8, 9, 11

42 U.S.C. § 18091(2)(J) 8

Community Living Assistance Services and Support ("CLASS") Act, Pub. L. No. 111-148, §§ 8001-8002, 124 Stat. 119, 828-47 (2010), repealed, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013) 31

Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013) 31

LEGISLATIVE MATERIALS

156 Cong. Rec. H2207 (daily ed. Mar. 22, 2010) (statement of Rep. Burgess) 30

156 Cong. Rec. H2423-H2424 (daily ed. Mar. 25, 2010) (statement of Rep. Waxman) 30

157 Cong. Rec. S737 (daily ed. Feb. 15, 2011) (statement of Sen. Franken) 12-13

Affordable Health Care for America Act, H.R. 3962, 111th Cong. tit. III, § 301 (2009) 29

Affordable Health Care for America Act, H.R. 3962, 111th Cong. tit. III, § 343 (2009) 29

Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (2009), *available at* http://www.cbo.gov/sites/default/files/11-30-premiums.pdf 15

Cong. Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's February 2014 Baseline* (Feb. 2014), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf 10

Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform: Hearing Before the S. Comm. On Finance, 111th Cong. 37-38 (Sept. 25, 2009) (statement of Sen. John Kerry) 13

Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means, 111th Cong. 13 (2009) (statement of Uwe Reinhardt, Prof. of Econ., Princeton Univ.) 14

H.R. 4872, the Reconciliation Act of 2010: Hearing Before the H. Comm. on Rules, 111th Cong. (2010) (statement of Rep. Andrews) 12

H.R. Rep. No. 111-443, pt. II (2010), *reprinted in* 2010 U.S.C.C.A.N. 474 7

Roundtable Discussion on Comprehensive Health Care Reform: Hearings Before the S. Fin. Comm., 111th Cong. 501-06 (2009) (written comments of Sandy Praeger, on behalf of the National Association of Insurance Commissioners) 13

Staff of J. Comm. on Taxation, 111th Cong., JCX-18-10, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," As Amended, In Combination with the "Patient Protection and Affordable Care Act"* (Comm. Print 2010), *available at* https://www.jct.gov/publications.html?func=startdown&id=3673 15

OTHER AUTHORITIES

Jean M. Abraham, State Health Reform Assistance Network, *Predicting the Effects of the Affordable Care Act: A Comparative Analysis of Policy Microsimulation Models* (Mar. 2012), *available at* http://statenetwork.org/wp-content/uploads/2014/11/State-Network-SHADAC-Predicting-the-Effects-of-the-ACA1.pdf 17-18

America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (Dec. 2007), *available at* http://www.ahip.org/Individual-Market-Survey-2007/ 25

Annual Update of the HHS Poverty Guidelines, 79 Fed. Reg. 3593 (Jan, 22, 2014) 19

Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 New Eng. J. Med. 1713 (2013), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsa1212321 23-24

Linda J. Blumberg & John Holahan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, 361 New Eng. J. Med. 6 (2009) 13

Linda J. Blumberg, Matthew Buettgens & John Holahan, Urban Institute, *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in* King v. Burwell (Jan. 2015), *available at* http://www.urban.org/UploadedPDF/2000078-Characteristics-of-Those-Affected-by-King-v-Burwell.pdf 19, 20

Linda J. Blumberg, Matthew Buettgens & John Holahan, Urban Institute, *The Implications of a Supreme Court Finding for the Plaintiff in* King vs. Burwell*: 8.2 Million More Uninsured And 35% Higher Premiums* (Jan. 8, 2015), *available at* http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf 18, 19, 22

Brief of *Amici Curiae* Economic Scholars In Support of Petitioners Urging Reversal On the Minimum Coverage Issue, *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012) (No. 11-398), 2012 WL 135048 7-8

Tom Brown, America's Health Insurance Plans, *Lessons Learned: Washington State's 1993 Experiment with Health Insurance Reforms* (undated), *available at* http://thelink.ahip.org/sites/default/files/CaseStudy_WashingtonState_Final_spreads.pdf 22

David M. Cutler & Sarah Reber, *Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection*, 113 Q. J. Econ. 433 (1998). 7

Stan Dorn, Urban Institute, *Uninsured and Dying Because of it: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* (Jan. 2008), *available at* http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf 23

Christine Eibner & Evan Saltzman, RAND Corp., *Assessing Alternative Modifications to the Affordable Care Act* (2014), *available at* http://www.rand.org/pubs/research_reports/RR708.html 21

Angela Fowler-Brown, et al., *Risk of Cardiovascular Events and Death – Does Insurance Matter?*, 22 J. Gen. Internal Med. 502 (2007) 23

John A. Graves & Jonathan Gruber, *How Did Health Care Reform in Massachusetts Impact Insurance Premiums?*, 102 Am. Econ. Rev. 508 (2012) 25

Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & Law 71 (2000) 26

Health Insurance Policy Simulation Model, Methodology Documentation: *2011 National Version* (Dec. 14, 2011), *available at* http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf. 17

John Holahan et al., The Urban Institute, *The Cost of Not Expanding Medicaid* (July 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf 24

Kaiser Family Foundation, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* (Jan. 22, 2014), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors1.pdf 12

Freeman Klopott & Alex Nussbaum, *New York Health Exchanges Offer 50% Drop In Premiums*, Bloomberg (July 17, 2013, 11:29 AM), *available at* http://www.bloomberg.com/news/2013-07-17/new-york-insurance-rates-said-to-drop-about-50-for-individuals.html 27

David Leonhardt, *Health Care's Uneven Road to a New Era*, N.Y. TIMES, Oct. 5, 2010, at B1 6

Letter from Douglas Elmendorf, Director, CBO, to Rep. Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives (Dec. 6, 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43752-letterToChairmanIssa.pdf 14, 15

Letter from Kathleen Sebelius, Sec'y Health & Human Res. to Speaker John Boehner, U.S. House of Representatives (Oct. 14, 2011), *available at* http://kaiserhealthnews.files.wordpress.com/2011/10/boehner-.pdf. 31

Letter from Marilyn Tavenner, Dep't of Health & Human Servs. to Comm'r Gregory R. Francis, Office of Lieutenant Governor (July 16, 2014), *available at* http://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf 31, 32

National Ass'n of Insurance Commissioners, *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act* (2011), *available at* http://www.naic.org/store/free/ASE-OP.pdf 12

National Ass'n of Insurance Commissioners, Health Insurance & Managed Care Committee, *Implementation of the Affordable Care Act in the U.S. Territories* (Oct. 7, 2013), *available at* http://www.naic.org/documents/index_health_reform_comments_140501_naic_letter_us_territories_paper_final.pdf 32, 33

National Research Council, *Care Without Coverage: Too Little, Too Late* (2002) 23

Evan Saltzman & Christine Eibner, RAND Corp., *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* (2015), *available at* http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf 17

Theda Skocpol, *Why Congressional Budget Office Reports Are the Best Evidence of Congressional Intent About Health Subsidies*, Scholars Strategy Network, Jan. 2015, *available at* http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_skocpol_on_cbo_reports_as_evidence_about_health_subsidy_intent_finalfinal.pdf 15

Urban Institute Health Policy Center, *The Urban Institute's Health Microsimulation Capabilities* (July 19, 2010), *available at* http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf 17

Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets* (Mar. 2012), *available at* http://www.ahip.org/Issues/Documents/2012/The-Impact-of-Guaranteed-Issue-and-Community-Rating-Reforms-on-Individual-Insurance-Markets.aspx. 25, 26, 27, 28

INTEREST OF *AMICI CURIAE*[1]

Amici curiae are a bipartisan group of 52 distinguished professors and internationally recognized scholars of economics who have taught and researched the economic forces operating in the health care and health insurance markets. The Economic Scholars include economists who have served in high-ranking positions in the Johnson, Ford, Carter, George H.W. Bush, Clinton, George W. Bush, and Obama administrations; three Nobel Laureates in Economics; three recipients of the John Bates Clark medal, which is awarded biennially to the American economist under 40 who has made the most significant contribution to economic thought and knowledge; one of only two social scientists awarded the Alan T. Waterman Award, usually reserved for physical scientists; five recipients of the Arrow award for best paper in health economics; and three recipients of the American Society of Health Economists Medal, which is awarded biennially to the economist aged 40 or under who has made the most significant contributions to the field of health economics. A complete list of the Economic Scholars is provided in the Appendix at the back of this brief.

Amici believe that reform of the health care system is essential to constraining the growth of health care spending and to extending health insurance coverage, and that such reforms cannot succeed without premium subsidies for people with low or moderate incomes.

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[1] No person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for the parties have consented to the filing of this brief, and letters of consent have been filed with the clerk.

Amici submit this brief to explain the economic reasons why premium subsidies are essential to achieving the reforms of the health care system that Congress sought through the Affordable Care Act ("ACA"), and to urge that the ACA cannot conceivably achieve those reforms if it is interpreted in the manner proposed by Petitioners.

SUMMARY OF ARGUMENT

A central aim of the ACA is to "achieve near-universal coverage" by making health insurance available and affordable to as many Americans as possible – a goal that can be achieved only by subsidizing the premiums of low- and middle-income Americans who do not qualify for Medicaid, and who otherwise would be unable to afford health insurance. 42 U.S.C. § 18091(2)(D). Over 6 million Americans currently use subsidies to purchase health insurance from the Exchanges operated by the federal government, where individuals and families can compare and shop for non-group health insurance. That number will grow as uninsured people continue to sign up for health insurance through the Exchanges.

Congress well understood the importance of subsidies to the ACA reforms. The basic economic framework undergirding that statute can be analogized to a stool with three legs. All three legs are necessary to foster stable, functioning insurance markets consistent with Congress's goal of broad, affordable coverage. The first leg is a series of *non-discrimination rules* that prevent insurers from charging higher premiums or denying coverage to people with pre-existing conditions or certain other

characteristics that raise the likelihood that they will need health care services. The second leg is the *individual mandate*, which requires nearly everyone, sick or healthy, to buy insurance they can afford. That avoids a situation in which only the sickest individuals sign up for insurance, resulting in increasing premiums to cover these costly customers. *Premium subsidies* comprise the third leg. These make insurance affordable for many who could not otherwise afford it, ensuring that all who are subject to the individual mandate have the means to comply with it. For that reason, Congress included affordability protection as part of the mandate, exempting those for whom insurance would be too expensive without subsidies.

Petitioners' interpretation would chop out the third leg from this three-legged stool in all States where the federal government operates an Exchange, destabilizing the insurance market in those States and frustrating Congress's clearly stated goal of broadening coverage. Without premium subsidies, millions of people will be exempt from the mandate altogether or will choose to pay the tax penalty rather than purchase costly insurance. Yet the sickest people will continue to sign up for insurance and insurers will have to cover them. The resulting higher premiums would threaten an adverse-selection "death spiral": as premiums increase, more and more healthy people will be exempt from the mandate and will forgo buying insurance, or, if not exempt, will choose to pay the tax penalty. As a result, sick people would form an ever-greater portion of the risk pool, causing premiums to rise and enrollment to fall. Such a result would be incompatible with the structure of the ACA's provisions, as well as

the wealth of legislative history showing that Congress understood premium subsidies to be an indispensible part of the ACA's reforms.

Economic modeling confirms what Congress understood: without premium subsidies for every eligible person who buys insurance on an Exchange, the ACA cannot achieve its goals. Both the Health Insurance Policy Simulation Model ("HIPSM") developed by the Urban Institute and the Comprehensive Assessment of Reform Efforts ("COMPARE") model developed by RAND Corporation predict that approximately *8 million fewer people* will be insured by 2016 if subsidies are unavailable. These models also predict that premiums will rise by 35% or more on the federally operated Exchanges in the absence of subsidies. Moreover, these effects would not be limited to the Exchanges themselves. Everyone who buys insurance in the non-group market would suffer, because the ACA requires that insurers treat everyone who buys insurance in the non-group insurance market as comprising a single risk pool. Accordingly, increases in health insurance premiums inside Exchanges will cause premiums to rise outside Exchanges as well.

The predictions of the HIPSM and COMPARE Models are corroborated by actual experience in Massachusetts, New York, and New Jersey. Each State tried to implement insurance reforms barring discrimination without simultaneously ensuring wide participation through subsidies and mandates. Insurance pools comprised sicker-than-average people, causing insurers' costs to skyrocket. Faced with a

costlier and riskier pool, some insurers simply stopped selling insurance in these States. Those who remained raised premiums to levels many could not afford. Congress, aware of these well-publicized experiments, could not have intended a similar outcome for the nation.

Petitioners *do not contest* that their position will result in millions of Americans losing insurance. *See* Pet'rs' Br. at 38-39. Instead, they contend that Congress *intended* to deny subsidies to those individuals – using those individuals' hardship and the prospect of unstable insurance markets to bludgeon States into setting up their own Exchanges. *Id.* at 32-43. In other words, Petitioners ask this Court to believe that Congress went to the trouble and expense of enacting federally operated Exchanges that it knew would be dysfunctional and doomed to failure from the outset. If Congress had truly wanted to deny benefits to citizens of States that did not set up their own Exchanges, then it would not have provided for federally facilitated Exchanges *at all*. As Judge Edwards explained in his dissent from the D.C. Circuit opinion, Congress did not intend to enact "a poison pill to the insurance markets in the States that did not elect to create their own Exchanges." *Halbig v. Burwell*, 758 F.3d 390, 415-16 (D.C. Cir. 2014) (Edwards, J., dissenting), *reh'g granted en banc, judgment vacated*, No. 14-5018, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014). Petitioners' contention to the contrary is an unreasonable construction of ACA's "text, structure, purpose, and history." *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 600 (2004). *Amici* therefore ask this Court to affirm the judgment of the district court.

ARGUMENT

I. THE FRAMEWORK ADOPTED BY CONGRESS IS PREMISED ON THREE NECESSARY AND INTERRELATED REFORMS, WHICH INCLUDE PREMIUM SUBSIDIES IN ALL EXCHANGES.

A. The ACA Rests On Three Interrelated Reforms.

Congress carefully structured the ACA to expand health insurance coverage while at the same time containing costs.[2] The expansion of coverage under the ACA depends on three closely related reforms. Each, correctly understood, is necessary and integral to the economic viability of the overall effort. In economic literature and the popular press, the interrelation among the ACA reforms is often described as a "three-legged stool."[3]

1. Non-discrimination. The first reform brings sweeping changes to the insurance markets by prohibiting various forms of discrimination by health insurers. Under the ACA's "guaranteed issue" and "community rating" requirements, insurers may no longer refuse to sell insurance or charge higher premiums to enrollees based on pre-existing conditions or other individualized characteristics, such as health status, medical condition, medical history, or claims

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[2] *See* 42 U.S.C. § 18091(2)(D) (articulating legislative goal of "achiev[ing] near-universal coverage"); *Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 132 S. Ct. 2566, 2670 (2012) ("[ACA] attempts to achieve near-universal health insurance coverage....").

[3] *See, e.g.*, David Leonhardt, *Health Care's Uneven Road to a New Era*, N.Y. TIMES, Oct. 5, 2010, at B1.

experience. 42 U.S.C. §§ 300gg, 300gg-3, 300gg-4. Taken together, the reforms comprising this first leg of the stool aim to make health insurance available to all Americans, regardless of factors that previously might have excluded or priced out many individuals. *See Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 132 S. Ct. 2566, 2585 (2012). These reforms are designed to prevent insurers from "cherry-pick[ing] healthy people and ... weed[ing] out those who are not as healthy." H.R. Rep. No. 111-443, pt. II, at 990 (2010), *reprinted in* 2010 U.S.C.C.A.N. 474, 512.

2. Individual Mandate. Congress recognized, however, that barring discrimination could not, on its own, solve all problems in the health insurance marketplace – and could generate new problems. Absent further reforms, insurers would have faced rising costs driven by a less healthy pool of insured persons. If costs rise and insurers must charge everyone (or, as under the ACA, everyone of a given age) the same premium, they must "significantly increase premiums on everyone." *NFIB*, 132 S. Ct. at 2585. Increased premiums, in turn, cause some healthier individuals to delay buying coverage, or to forgo coverage altogether, a phenomenon known as "adverse selection." Over time, adverse selection leads to an increasingly sick and costly pool of insured persons. The higher premiums threaten a chain reaction that economists refer to as a "death spiral."[4] *See* Brief of *Amici Curiae* Economic Scholars In

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[4] *See* David M. Cutler & Sarah Reber, *Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection*, 113 Q. J. of Econ. 433 (1998).

Support of Petitioners Urging Reversal On the Minimum Coverage Issue at 16-18, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (No. 11-398), 2012 WL 135048 ("NFIB Amici Brief"); *see also NFIB*, 132 S. Ct. at 2626 ("[Congress understood that simply prohibiting insurer discrimination] would trigger an adverse-selection death-spiral in the health-insurance market: Insurance premiums would skyrocket, the number of uninsured would increase, and insurance companies would exit the market." (Ginsburg, J., concurring in part)); *see* 42 U.S.C. § 18091(2)(I), (J).

Therefore, Congress included a second major reform in the ACA: the requirement that every American either purchase health insurance if it is affordable, or pay a penalty. *See* 26 U.S.C. § 5000A. This "individual mandate" was designed to ensure near universal participation in health insurance pools, whether as part of employer-sponsored group insurance or through the purchase of individual insurance on the State and Federal Exchanges authorized by the ACA.[5] By bringing millions of new Americans into these pools, the mandate would spread the risks and costs of coverage across the broad spectrum of the population, both healthy and sick. Congress specifically expected the mandate to "primarily affect[] healthy, often young adults who are less likely to need significant health care." *NFIB*, 132 S. Ct. at 2590. By "broaden[ing] the health insurance risk pool to include healthy individuals," 42 U.S.C.

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[5] The mandate does not extend to individuals already covered by federal health programs like Medicare or Medicaid.

§ 18091(2)(I), Congress sought to "lower health insurance premiums," *id.*, and "help[] counter the effect of forcing insurance companies to cover others who impose greater costs than their premiums are allowed to reflect." *NFIB*, 132 S. Ct. at 2590.

3. Premium subsidies. The mandate posed a critical question: Would currently uninsured individuals be able to *afford* health insurance, even when *required* by law to purchase it? If insurance were unaffordable, the mandate would not succeed in broadening the health insurance risk pool to include healthy individuals. Meanwhile, insurers – due to the dynamics discussed above – would face rapidly increasing costs and be forced either to exit the market or raise premiums, leading many people to abandon the Exchanges. "With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all." *NFIB*, 132 S. Ct. at 2674 (Scalia, J., dissenting).

Recognizing this problem, Congress enacted a third reform in the ACA – a premium subsidy for low- and middle-income individuals who otherwise could not afford health insurance. The ACA implements this subsidy through a tax credit, which is paid in advance directly to an individual's insurer. *See* 42 U.S.C. §§ 18081-18082; 26 U.S.C. § 36B. By subsidizing premiums, Congress ensured that most people would be able to buy health insurance on one of the authorized Exchanges without undue financial burden. The Congressional Budget Office ("CBO") has predicted, for example, that 20 million of the 24 million individuals purchasing insurance on the Exchanges (both State and

Federal) will avail themselves of tax credits.[6] The individual mandate can apply broadly only because the subsidies make insurance affordable to nearly all.

The importance of subsidies is underscored by the fact that Congress exempted from the mandate those for whom insurance would be unaffordable. In particular, the mandate does not apply to individuals for whom the cost of insurance – *after* premium subsidies – exceeds eight percent of annual household income. 26 U.S.C. § 5000A(e)(1)(A), (B)(ii). This exception shows that Congress intended that most individuals would pay less than this amount. If insurance premiums exceeded the eight percent threshold for nearly everyone, then the mandate would have no practical effect – everyone would be exempt. Congress avoided this problem by offering premium subsidies that would allow individuals to comply with the mandate.

Indeed, as discussed below, the best estimate is that if these subsidies were *not* available, 99% of otherwise subsidy-eligible persons enrolling through the federally run Exchanges would be exempt from the mandate, because insurance costs would exceed eight percent of their income. Without the push of the individual mandate and the pull of the premium tax credits, a great number of these people would have no viable option but to remain uninsured. Thus, without

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[6] *See* Cong. Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's February 2014 Baseline*, at Tables 2 & 3 (Feb. 2014), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf.

subsidies, Congress simply could not have achieved its primary purpose of achieving "near-universal coverage." 42 U.S.C. § 18091(2)(D).

B. Congress Intended To Make Subsidies Available To Participants On The Federally Run Exchanges.

All three legs of the stool – non-discrimination, the individual mandate, and premium subsidies – are necessary to achieve the ACA's goals. And it is impossible to parse the statute without concluding that Congress understood and intended all three legs to work together. It is absurd to argue that Congress set up federally facilitated Exchanges while simultaneously denying participants the subsidies necessary to make those Exchanges functional. Absent the means or obligation to pay, people would rationally wait to buy insurance until they became sick or were at high risk of becoming sick. *See* 42 U.S.C. § 18091(2)(I) (finding that, if there were no mandate, "many individuals would wait to purchase health insurance until they needed care"). Such behavior would lead the Exchanges to be populated with sicker-than-average individuals, resulting in increasing premiums that would further discourage healthy people from buying insurance. At the extreme, "insurance" would effectively be prepayment, and thereby defeat the very purpose of insurance, which is to protect people from financial ruination at the time of illness.

Moreover, these effects would *not* be limited just to the Exchanges. The ACA explicitly requires insurers to treat as a single risk pool plans that are offered both inside and outside of an Exchange. *See* 42 U.S.C.

§ 18032(c)(1).[7] Thus, as premiums *inside* the Exchanges rise, premiums *outside* the Exchanges would rise as well, making insurance less affordable not just for low- and middle-income individuals who might have qualified for subsidies, but also for the sizable population that has traditionally relied on the non-group market for insurance – *e.g.*, the self-employed, early retirees, individuals in employment transitions, and individuals employed by small businesses that do not offer insurance coverage. Again, given that Congress tied the fortunes of these groups together, it is implausible to construe the ACA as condemning them to massive premium increases.

The legislative history confirms that Congress understood the importance of the ACA's interrelated reforms. *See, e.g., H.R. 4872, the Reconciliation Act of 2010: Hearing Before the H. Comm. on Rules*, 111th Cong. (2010) (statement of Rep. Andrews) (explaining that ending discrimination based on pre-existing conditions "doesn't fit together if you don't take the next step and the next step," that is, ensuring broad participation in the insurance market, which cannot be accomplished without subsidies); 157 Cong. Rec. S737

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[7] *See also* Nat'l Ass'n of Ins. Comm'rs, *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act* 2 (2011), *available at* http://www.naic.org/store/free/ASE-OP.pdf ("[P]lans offered in the Exchange must receive the same pricing if sold outside the Exchange"); Kaiser Family Found., *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* 3-4 (Jan. 2014), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2014/01/ 8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors1.pdf.

(daily ed. Feb. 15, 2011) (statement of Sen. Franken) (describing the ACA as a "[t]hree-legged stool" and noting that, "[i]f you take any leg out, the stool collapses").[8]

The necessity of the three-legged stool was also well understood in the economic community, as well as among insurers and other key stakeholders, at the time of ACA's enactment.[9] Accordingly, Congress received expert input from regulators and economists – including some of the Economic Scholars joining this brief – explaining how all three legs of the stool were critical in achieving Congress's goal of widespread, affordable coverage for all Americans. *See, e.g.*, *Roundtable Discussion on Comprehensive Health Care Reform: Hearings Before the S. Fin. Comm.*, 111th Cong. 501-06 (2009) (written comments of Sandy Praeger, on behalf of the National Association of Insurance Commissioners) ("As for proposals that

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[8] *See also, e.g.*, *Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform: Hearing Before the S. Comm. On Finance*, 111th Cong. 37-38 (Sept. 25, 2009) (statement of Sen. John Kerry) (recommending Congress follow Massachusetts' approach of mandating coverage while subsidizing premiums, to "make insurance affordable" and "create a bigger pool of people covered"); *id.* at 38 (noting health care reform in Massachusetts included guaranteed issue requirements, an individual mandate, and a "subsidy up to 300 percent of poverty to help people buy in").

[9] *See, e.g.*, Linda J. Blumberg & John Holahan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, 361 New Eng. J. Med. 6, 6-7 (2009); *Roundtable Discussions on Comprehensive Health Care Reform: Hearing Before the Senate Comm. On Finance*, 111th Cong. 502-04 (2009) (written comments of Sandy Praeger, National Association of Insurance Commissioners).

could result in severe adverse selection, such as guaranteed issue ... regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and *appropriate income-sensitive subsidies to make coverage affordable.*" (emphasis added)); *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 13 (2009) (statement of Uwe Reinhardt, Prof. of Econ., Princeton Univ.) (noting that "adequate public subsidies" are instrumental to achieving Congress's purpose of making health insurance available and affordable to all Americans).

Indeed, the notion that subsidies would be available only on the State Exchanges was so obviously fatal to the ACA's goals that Congress never considered it. As the Director of the CBO explained in a letter to Representative Issa, "the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the [ACA] legislation was being considered."[10] Indeed, a recent study analyzed a "complete list" of CBO reports on the proposed health care legislation, and observed that "no one from either party asked CBO to analyze or project subsidies [that might be] available to people in some states but not

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[10] Letter from Douglas Elmendorf, Director, CBO, to Rep. Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives ("Elmendorf Letter") (Dec. 6, 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/ 43752-letterToChairmanIssa.pdf.

others."[11] Instead, the "CBO had anticipated, in its analyses, that the credits would be available in every state."[12] In sum, the only sensible construction of the ACA's provisions, structure, and purpose is that the subsidies would be available to all Exchange participants. Concluding otherwise means finding that Congress sought to legislate into existence a signature new program that it understood would immediately fail. This Court should reject that irrational construction of the statute and instead construe it in a manner that is consistent with the economic logic on which it is based.

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[11] Theda Skocpol, *Why Congressional Budget Office Reports Are the Best Evidence of Congressional Intent About Health Subsidies* 2, Scholars Strategy Network, Jan. 2015, *available at* http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_skocpol_on_cbo_reports_as_evidence_about_health_subsidy_intent_finalfinal.pdf.

[12] Elmendorf Letter; *see also* Staff of J. Comm. on Taxation, 111th Cong., JCX-18-10, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," As Amended, In Combination with the "Patient Protection and Affordable Care Act"*, at 14 (Comm. Print 2010), *available at* https://www.jct.gov/publications.html?func=startdown &id=3673 (stating that "[p]remium assistance credits may be used for any plan purchased through an exchange"); Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6-7, 19 (2009) (estimating that about 57% of non-group enrollees would receive subsidies "via the new insurance exchanges"), *available at* http://www.cbo.gov/sites/default/files/11-30-premiums.pdf.

II. Economic Analysis Confirms What Congress Understood: The ACA Cannot Function Without Premium Subsidies.

Economic analysis confirms what Congress understood: the ACA's benefits will not be available nationwide if subsidies are available only to those who purchase insurance through the State-administered Exchanges. In fact, residents of states with federally facilitated Exchanges will be *worse off* than they were before the ACA was enacted. That is the lesson of economic modeling, as well as the natural experiments of jurisdictions (of which Congress was aware) that have attempted to reform health care without providing subsidies to increase access.

A. Economic Modeling Shows That, Absent Premium Subsidies, Health Insurance Will Be Unaffordable in the Majority of States.

The Urban Institute and the RAND Corporation have independently developed sophisticated economic models that allow for a robust prediction of outcomes in the health care system, depending on various policy changes. The Urban Institute's Health Insurance Policy Simulation Model ("HIPSM") uses two primary sets of data: (1) fixed information on individuals, derived largely from the Current Population Survey ("CPS") and the Medical Expenditure Panel Survey—Household Component ("MEPS-HC"); and (2) varying information on policy parameters, which inform the changes in price and eligibility of various forms of

insurance.[13] The model has been used since 2009 to simulate outcomes under a variety of state and national policy proposals, including various options that were explored by Congress in the run-up to the ACA's enactment.[14]

Like the Urban Institute's HIPSM, the RAND Corporation's COMPARE Model starts with fixed survey data on individuals and introduces into the model proposed health reforms to examine their effects on the insurance market. Also like HIPSM, the model has undergone a thorough calibration process, ensuring that it is able to represent accurately the insurance market that actually existed before the ACA's enactment.[15] The HIPSM and COMPARE Models have been cited as two of the leading options for modeling health insurance reforms such as the ACA.[16]

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[13] *See* Health Ins. Policy Simulation Model, *Methodology Documentation: 2011 National Version* 4-5 (Dec. 14, 2011), *available at* http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf.

[14] *See* Urban Inst. Health Policy Ctr., *The Urban Institute's Health Microsimulation Capabilities* 2 (July 19, 2010), *available at* http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf.

[15] Evan Saltzman & Christine Eibner, RAND Corp., *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* 3 (2015) ("COMPARE Analysis"), *available at* http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf.

[16] *See, e.g.*, Jean M. Abraham, State Health Reform Assistance Network, *Predicting the Effects of the Affordable Care Act: A Comparative Analysis of Policy Microsimulation Models* 5 (Mar. 2012), *available at* http://statenetwork.org/wp-

Recently, both the HIPSM and the COMPARE Model have independently been used to simulate the economic effects of eliminating tax credits for individuals purchasing non-group insurance on the Exchanges operated by the federal government.[17] These analyses confirm that the health care reforms effected by the ACA will not be economically viable without premium subsidies for insurance policies purchased on all Exchanges.

The models predict, first, that average annual premiums would rapidly and substantially rise if Petitioners were to prevail. Under such a scenario, the HIPSM predicts a 35% increase in the average annual premium for an individual purchasing non-group insurance in a State with a federally run Exchange. This figure takes into account the fact that the purchasing patterns of individuals would change absent premium subsidies – for instance, fewer individuals would purchase the more generous (and costlier) "silver" and "gold" plans. The COMPARE Model also

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content/uploads/2014/11/State-Network-SHADAC-Predicting-the-Effects-of-the-ACA1.pdf (comparing methodologies of these and other health policy microsimulation models).

[17] The models assumed a state of "full implementation equilibrium" by 2016, meaning that the behavior of individuals and employers is assumed to have fully adjusted to the subsidy elimination and that knowledge of this change has peaked. Linda J. Blumberg, Matthew Buettgens & John Holahan, Urban Institute, *The Implications of a Supreme Court Finding for the Plaintiff in* King vs. Burwell: *8.2 Million More Uninsured And 35% Higher Premiums* 2 (Jan. 2015) ("HIPSM Analysis"), *available at* http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf; *see* COMPARE Analysis at 3 (noting that the analysis assumes full utility maximization).

predicts a steep rise in premiums for individuals purchasing non-group insurance in a State with a federally run Exchange. That model examines the change in average premiums assuming individuals were to attempt to purchase the same level of coverage absent any subsidies. For a non-smoker seeking to purchase a middle-tier (or "silver") plan, the model predicts a 47% increase in premiums were Petitioners to prevail.

To put this in hard dollar terms, consider the nearly 5 million people who would enroll in subsidized coverage in 2016 and have incomes below 200 percent of the Federal Poverty Line.[18] These persons would face dramatically escalated out-of-pocket costs were they to continue to buy the same coverage in a market without subsidies. For instance, the median out-of-pocket cost for a premium on a single policy would jump from $763 to $5,589. For a family policy, the out-of-pocket cost would jump from $1,114 to $14,318. *See* Linda J. Blumberg, Matthew Buettgens & John Holahan, Urban Institute, *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in* King v. Burwell 7 (Jan. 2015), *available at* http://www.urban.org/UploadedPDF/2000078-Characteristics-of-Those-Affected-by-King-v-Burwell.pdf.

As a result of these premium increases, fully *99 percent* of individuals and families who would otherwise

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[18] HIPSM Analysis at 5. In 2014, the Federal Poverty Line was set at $15,730 for a family of two and $23,850 for a family of four. Annual Update of the HHS Poverty Guidelines, 79 Fed. Reg. 3593, 3593 (Jan. 22, 2014).

enroll in subsidized insurance would become exempt from the individual mandate. *Id.* at 1. That is because, for this 99 percent, the cost of health insurance would substantially exceed 8 percent of household income. For example, the median single adult with an income below 200 percent of the Federal Poverty Line can currently obtain coverage through an Exchange by spending 4.1 percent of her income. *Id.* at 7. If subsidies were to disappear under Petitioners' theory, however, this same adult would need to spend 29.6 percent of her income to retain the exact same level of coverage. *Id.* Insurance would likewise become unaffordable for a family with an income under 200 percent of the Federal Poverty Line. Under the ACA as currently implemented, the median family can obtain coverage by spending 3.6 percent of its collective income. If Petitioners prevail, this family would need to spend 48.9 percent of their income – an over tenfold increase – to retain the same coverage. *Id.*

Congress viewed these projected premiums as unaffordable. It would not have gone to the trouble of setting up federally operated Exchanges to effectuate an individual mandate, only to have those Exchanges sell insurance so expensive that virtually every potential buyer would be exempt.

In addition to predicting a steep and swift escalation in premiums, both the HIPSM and COMPARE models predict a significant and rapid drop in the number of insured Americans. Both models[19] predict that

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[19] The HIPSM Model predicts that an additional 8.2 million individuals would become uninsured and the size of the nongroup market would fall by 9.8 million people. The COMPARE Model

eliminating subsidies as Petitioners seek would increase the number of uninsured Americans *by at least 8 million* by 2016.[20] Certain States would be particularly hard hit; for instance, the HIPSM predicts an additional 1 million uninsured in Florida and close to 1.5 million additional uninsured in Texas.

Analyses released in conjunction with the HIPSM and COMPARE models describe how adverse selection would be triggered by these changes and would make insurance markets dysfunctional. The non-group market would become crowded with individuals in immediate need of insurance – specifically, sick individuals who would continue to purchase insurance notwithstanding its escalated cost. Because the remaining pool would be costlier to insure, many insurers would exit the market altogether, in turn further driving up the cost of premiums.[21] Furthermore, all of these market-based effects can be expected to transpire quickly.[22] The authors of the

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predicts that 9.6 million fewer individuals would buy nongroup insurance and that 1.6 million of these individuals would find coverage through another source.

[20] This translates to a near 70 percent decrease in the number of insured in the nongroup marketplace, relative to the anticipated coverage under the ACA absent Petitioners' change.

[21] Researchers at RAND have stated that, "[i]f the ACA's subsidies are eliminated entirely, our model predicts a near death spiral – that is, sharp premium increases and drastic enrollment declines in the individual market." Christine Eibner & Evan Saltzman, RAND Corp., *Assessing Alternative Modifications to the Affordable Care Act* 25 (2014), *available at* http://www.rand.org/pubs/ research_ reports/RR708.html.

[22] *Amicus curiae* Consumers' Research, writing in support of Petitioners, contends that these adverse effects are nothing but

HIPSM analysis, who join this brief, have noted that, "[u]nlike regulatory changes alone that could take up to a few years to work through a market, eliminating financial assistance will make coverage unaffordable to many enrollees immediately, causing them to drop coverage upon receiving their much higher bills. Insurers can be expected to revise their premiums accordingly at the next opportunity."[23]

"speculative hyperbole" that "are likely to [occur] gradually." *See* Brief of Consumers' Research As *Amicus Curiae* In Support of Petitioners at 16-17. But *amicus* Consumers' Research concedes that "the problem of adverse selection" that would result if Petitioners were to prevail is "real" and "may pose a long-term threat to insurance markets." *Id.* at 16. Moreover, Consumers' Research's misleading argument relies on a distortion of the evidence. For example, Consumers' Research claims that although Washington state "implemented health-care reform in 1993 without imposing an individual mandate[, s]ignificant adverse effects in the state's health insurance market did not appear until 'the late 1990s.'" *Id.* at 23. Contrary to Consumers' Research's assertion, however, Washington state's 1993 comprehensive reforms embodied the three-legged stool – including non-discrimination, premium caps (rather than premium subsidies), *and an individual mandate.* Tom Brown, America's Health Insurance Plans, *Lessons Learned: Washington State's 1993 Experiment with Health Insurance Reforms* 2-3 (undated), *available at* http://thelink.ahip.org/sites/default/files/CaseStudy_WashingtonState_Final_spreads.pdf. But in July 1995, the state legislature repealed a number of the reforms, including the individual mandate and premium caps, and within only three and a half years of those repeals, the "'death spiral' was on full display" and "[t]he insurance market for individuals had utterly collapsed." *Id.* at 7, 8. As discussed in notes 27 and 34, *supra*, Consumers' Research's contentions regarding New York and New Jersey fare no better.

[23] HIPSM Analysis at 7.

In addition to rendering the federally run Exchanges largely nonfunctional, these dynamics would create damaging spillover effects. First, overall prices in the individual insurance market, both inside *and outside* of Exchanges, are likely to be much higher than they are today. As explained above, there would be spillover effects to the non-group market as a whole because the ACA requires insurers to treat all non-group enrollees the same, regardless if they purchase insurance on the federally run Exchanges. *See supra* at 10.

The costs to society as a whole would also be enormous. Millions of Americans who would have received necessary medical care would be unable to afford and hence denied access to that care.[24] Millions of Americans, moreover, who were to be protected from the dire financial consequences of being uninsured would be subjected to increased bankruptcy risk and the enormous negative mental health implications of that stress.[25] And hospitals that were to see a

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[24] *See, e.g.*, Nat'l Research Council, *Care Without Coverage: Too Little, Too Late* (2002); Stan Dorn, Urban Inst., *Uninsured and Dying Because of it: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* (Jan. 2008), *available at* http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf; Angela Fowler-Brown, et al., *Risk of Cardiovascular Events and Death – Does Insurance Matter?*, 22 J. Gen. Internal Med. 502 (2007).

[25] *See* 42 U.S.C. § 18091(2)(G) (finding that "62 percent of all personal bankruptcies are caused in part by medical expenses," and that the provisions of the ACA "will improve financial security for families"); *see also* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 New

substantial reduction in the costs of their uncompensated care would see those costs remain high, at the same time that the ACA is cutting back on their federal subsidies to support such care.[26] Finally, the coverage and access-to-care disparities that would result from eliminating subsidies in States with federally run Exchanges would exacerbate the consequences of the decision by many of those same States to decline federal support for Medicaid expansion.[27]

B. State-Based Reform Efforts Confirm That Premium Subsidies Are Essential To Properly Functioning Exchanges.

The concept of the three-legged stool and the results of the HIPSM and COMPARE modeling are corroborated by evidence from State-based experiments with health insurance reform, which were well-known to Congress. These jurisdictions provide evidence that health care reform is entirely impracticable without premium subsidies.

Massachusetts. The tumultuous experience in Massachusetts demonstrates why all three legs are necessary to make broad coverage affordable and stable. The State first tried to reform the health insurance market in 1996. The legislature passed

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Eng. J. Med. 1713 (2013), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

[26] *Cf.* John Holahan et al., Urban Inst., *The Cost of Not Expanding Medicaid* 11-13 (July 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf.

[27] *Id.* at 17.

guaranteed issue and community rating laws that prohibited insurers from discriminating in the issuance of insurance on the basis of health status or other factors, prohibited insurers from varying premium rates based on health status, and restricted the amount by which insurers might vary rates based on characteristics such as age or sex. Following these reforms, average premiums for individual coverage reached $8,537 per year, the most expensive in the nation by a wide margin.[28] Those premiums fell only after Massachusetts implemented a second wave of reforms that included *both* an individual mandate *and* premium subsidies for low-income individuals. With the combination of those reforms, premiums for individual coverage in Massachusetts dropped by 35% compared to the national average between 2006 and 2009.[29]

New York. In 1993, in what was "[w]idely regarded as the most far reaching package of [health insurance] reforms" of the time, New York implemented guaranteed issue and community rating reforms, but not a mandate or subsidies.[30] In the years following

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[28] *See* America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* 8 (Dec. 2007), *available at* http://www.ahip.org/Individual-Market-Survey-2007/.

[29] *See* John A. Graves & Jonathan Gruber, *How Did Health Care Reform in Massachusetts Impact Insurance Premiums?*, 102 Am. Econ. Rev. 508, 511 (2012).

[30] *See* Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets* 37 (Mar. 2012) ("*Impact of Guaranteed Issue*"), *available at* http://www.ahip.org/Issues/Documents/2012/The-Impact-of-

these reforms, premiums rose substantially in the non-group insurance market, with some insurers increasing premium rates by as much as 40% by early 2000.[31] Individuals who obtained insurance through the non-group market were older, experienced a greater incidence of high-cost health conditions, had higher hospital utilization, and were generally costlier to cover than individuals insured through group policies.[32] Despite subsequent remedial reform efforts by the legislature, premiums continued to skyrocket, and individual market enrollment continued to plummet.[33] This situation began to change only after the ACA's

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Guaranteed-Issue-and-Community-Rating-Reforms-on-Individual-Insurance-Markets.aspx. In their brief, *amicus* Consumers' Research misleadingly suggests that the experience in New York demonstrates that adverse selection problems only "gradually produced the kinds [of] problems anticipated here." *See* Consumers' Research Br. at 22-23. Specifically, *amicus* claims that after three years, the New York reforms did not produce "statistically" significant shifts in the insurance market "'from similar shifts in two neighboring states' that had not enacted similar reforms and that 'the main impact of the reforms in New York was a shift from traditional indemnity plans towards managed care plans.'" *Id.* at 23 (quoting *Impact of Guaranteed Issue*, at 37). But Consumers' Research's selective quotation of Wachenheim & Leida's report hides the authors' actual conclusion: that in the three years following New York's enactment of inadequate reforms (which included neither an individual mandate nor premium subsidies), the scheme "effectively eliminated the commercial indemnity market in New York with the largest individual health insurer existing the market." *Impact of Guaranteed Issue*, at 38.

[31] Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & Law 71 (2000).

[32] *Id.*; *Impact of Guaranteed Issue*, at 38.

[33] *Impact of Guaranteed Issue*, at 38-39.

exchange-based subsidies and individual mandate came into effect for the 2014 plan year. Indeed, premiums set by insurers for 2014 ACA-compliant plans in the non-group insurance market have dropped dramatically relative to the pre-ACA levels.[34]

New Jersey. The experience of New Jersey, which enacted guaranteed issue and community rating reforms in 1992, shows evidence of the "adverse selection death spiral" of which economists warn.[35] As the reforms took hold in the market, premiums increased dramatically; one carrier raised premiums by 415% over a two-year period. Additionally, the number of carriers in the market shrank from a high of 29 in 1995 to only 6 in 2012, and the proportion of residents with insurance fell.[36] Ultimately, New Jersey's reform experiment failed even to maintain the pre-reform rate of insurance in the State.[37]

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[34] *See* Freeman Klopott & Alex Nussbaum, *New York Health Exchanges Offer 50% Drop In Premiums*, Bloomberg (July 17, 2013, 11:29 AM), *available at* http://www.bloomberg.com/news/2013-07-17/new-york-insurance-rates-said-to-drop-about-50-for-individuals.html.

[35] *Impact of Guaranteed Issue*, at 31.

[36] *Id.* at 30.

[37] *Id.* at 33-34. Again, *amicus* Consumers' Research's brief distorts the effects of New Jersey's reforms, suggesting that they "were far from disastrous and in some respects could be seen as positive." *See* Consumers' Research Br. at 24. As Consumers' Research asserts, the evidence shows that during the first three years following New Jersey's reforms (which included neither an individual mandate nor premium subsidies), "the number of carriers in the individual insurance market 'increased dramatically.'" *Id.* (quoting *Impact of Guaranteed Issue*, at 30). What Consumers' Research failed to note, however, was that in

III. Petitioners Offer No Plausible Explanation For Why Congress Would Have Established A Backup Federal Exchange Doomed To Failure.

A. Petitioners' "Poison Pill" Theory Is Without Support.

Tellingly, Petitioners offer no plausible counter-model to explain how Congress could achieve its goals of broadening coverage and making health insurance affordable absent all of the three "legs" described above. Instead, Petitioners posit that Congress purposely dangled the carrot of affordable health insurance for low-income families and individuals in front of States to encourage States to establish exchanges. In Petitioners' conception, the stick of having to explain to their voters that they had deprived them of billions of dollars by failing to establish an Exchange would so frighten State officials that, eventually, every State would create an Exchange and, consequently, uninsured Americans nationwide would become eligible for premium subsidies. Pet'rs' Br. at 32.

That account – for which Petitioners provide no evidentiary support – is implausible and indeed irreconcilable with the ACA's structure and purpose. First, as explained above, Congress fully understood

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that same three year period, a number of insurers reported substantial losses (which, under the scheme, were shared by all insurers in proportion to their market shares), and within four years of the reforms, carriers "were raising rates significantly . . . , losing enrollment, and exiting the market." *Impact of Guaranteed Issue*, at 30.

the economic need for the ACA to rest on the three interlocking reforms, of which subsidies were one primary component. Nothing in the record suggests that Congress intended to adopt what it knew – from prior state reform efforts – would be an economically disastrous approach of dramatically limiting subsidies only to participants in State exchanges. Second, the Congressional Budget Office never entertained the possibility that subsidies would not be available across all Exchanges. *See supra.* Members of Congress consulted regularly with the CBO, yet not one of them indicated that the CBO's work was at odds with congressional intent. Third, initial versions of the ACA indicate that premium subsidies were understood to be available for enrollees buying insurance on the federal Exchange. Premium tax credits were included in the House bill even though that bill provided for a single Federal exchange rather than State exchanges. Affordable Health Care for America Act, H.R. 3962, 111th Cong. tit. III, § 301 (2009) (establishing single, federal exchange); *id.* tit. III, § 343 (providing for "affordability premium credit"). In the endgame debate in which the House debated Senate language, it is inconceivable that the House would have accepted a change sure to cripple the federally run Exchanges. Petitioners point to nothing in the legislative record to support their economically implausible argument that the purpose of the subsidies changed from the initial House proposal to the final Act. Instead, as Judge Edwards put it, Petitioners peddle a "narrative concocted to provide a colorable explanation for the otherwise risible notion that Congress would have wanted insurance markets to collapse in States that

elected not to create their own Exchanges." *Halbig*, 758 F.3d at 416 (Edwards, J., dissenting).

If anything, the record establishes that Congress created the State Exchanges not because it intended the federally run Exchanges to be dysfunctional, but simply to provide States the option of creating their own Exchanges. The federally run Exchanges remained available to those States that lacked the resources, expertise, or desire to build their own from the ground up.[38]

B. Congress's Treatment of the Federal Territories Offers No Support to Petitioners' Position.

The D.C. Circuit decision, which Petitioners emphasize, itself rested heavily on the notion that Petitioners' interpretation of the statute is not absurd because Congress in fact "did the unimaginable" in the federal territories. *See Halbig*, 758 F.3d at 410.[39] The

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[38] *See, e.g.*, 156 Cong. Rec. H2423-H2424 (daily ed. Mar. 25, 2010) (statement of Rep. Waxman) ("Under the new law, 'a State is free to establish a health insurance exchange if it so chooses. But if it declines, the Secretary will establish an exchange.' This is a strong example of what the Supreme Court has recognized as an appropriate exercise of federal power to encourage State participation in important federal programs."); 156 Cong. Rec. H2207 (daily ed. Mar. 22, 2010) (statement of Rep. Burgess) ("[W]hat happens in a State that doesn't set up an exchange? ... [T]he [federal government] ... is going to ... [set] up ... a national exchange that every State that doesn't have a State-based exchange, that their citizens can buy through this national exchange.")

[39] The D.C. Circuit decision, *see Halbig*, 758 F.3d at 410, also relied upon the notion that Congress purportedly enacted a one-

decision stated that, in the territories, the ACA "imposes guaranteed issue and community rating requirements without an individual mandate," essentially enacting a one-legged stool. *Id.* But the panel's premise about what the ACA legislated for the federal territories is simply incorrect. In a letter issued six days before the D.C. Circuit decision, the Department of Health and Human Services (HHS) recognized that, in fact, Congress did *not* intend to apply the non-discrimination leg of the stool in the territories.[40]

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legged stool in the Community Living Assistance Services and Support ("CLASS") Act, which required the Secretary of HHS to establish a community-based long-term care insurance program. *See* Pub. L. No. 111-148, §§ 8001-8002, 124 Stat. 119, 828-47 (2010), *repealed*, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013). That argument, however, overlooks Congress' express concern that the CLASS Act program might not be actuarially sound. Congress directed the Secretary of HHS to establish the program *only* if found to be actuarially sound. *See* 42 U.S.C. § 300*ll*-2(a)(1) (2012) ("The Secretary ... shall develop at least 3 *actuarially sound* benefit plans..." (emphasis added)). Congress further directed the board tasked with administering the CLASS Act to issue a report including an annual certification as to whether the program was actuarially sound. *See* 42 U.S.C. § 300*ll*-5(c)(2)(B)(i)(III) (2012). The Secretary of HHS subsequently reported to Congress that the CLASS program could not be made actuarially sound. *See* Letter from Kathleen Sebelius, Sec'y Health & Human Res. to Speaker John Boehner, U.S. House of Representatives (Oct. 14, 2011), *available at* http://kaiserhealthnews.files.wordpress.com/2011/10/boehner-.pdf. Congress then repealed the statute. *See* Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013). Tellingly, Congress exhibited no concern about the actuarial soundness of the ACA Exchanges.

[40] *See* Letter from Marilyn Tavenner, Dep't of Health & Human Servs. to Comm'r Gregory R. Francis, Office of Lieutenant

HHS was prompted to revisit this section of the ACA by the real-world experience of the U.S. Virgin Islands ("USVI") in implementing the various market reforms without either an individual mandate or subsidies. A report from the National Association of Insurance Commissioners, analyzing evidence from the USVI experience, explains that, prior to the market reforms, only one insurer sold individual policies in the USVI; since the enactment of those reforms, that insurer ceased selling new policies, and USVI residents have been entirely unable to purchase non-group insurance.[41] That is, the fear of an adverse-selection

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Governor (July 16, 2014) ("Tavenner Letter"), *available at* http://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf. There is nothing untoward about HHS's decision to revisit its analysis of the statutory language, contrary to the arguments presented by *amicus curiae* Cato Institute. *See* Brief Of *Amici Curiae* Cato Institute & Prof. Blackman In Support of Petitioners at 30-32. As the Tavenner Letter explains, HHS's prior analysis of the law incorrectly relied on an earlier definition of the word "state" rather than the definition used by the ACA itself. *See* Tavenner Letter. That unintended error created unintended consequences in the territories' health insurance marketplace, which HHS was entitled to correct. *See Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417 ("The Secretary [of HHS] is not estopped from changing a view she believes to have been grounded upon a mistaken legal interpretation."); *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (agency "need not demonstrate to a court's satisfaction that the reasons for [a] new policy are *better* than the reasons for the old one; it suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates" (emphasis in original)).

[41] *See* Nat'l Ass'n of Ins. Comm'rs, Health Ins. & Managed Care Comm., *Implementation of the Affordable Care Act in the U.S.*

"death spiral" dissuaded insurers from offering individual policies, the type of coverage Congress designed the exchanges to provide. The National Association of Insurance Commissioners concluded that "[w]ithout some action to prevent a cycle of adverse selection in the territories" – such as a mandate in conjunction with subsidies – "implementation of the ACA's market reforms is likely to lead to a result that is the opposite of what the ACA intended – higher premiums, less competition, and more Americans without health insurance coverage."[42]

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In sum, Petitioners' argument cannot be squared with what Congress correctly understood to be the case: that the goals of the ACA could not be accomplished without providing subsidies to low and middle income individuals and families, regardless of whether they purchased insurance on a State or federal Exchange. This Court should reject an interpretation of the ACA that cannot be, and is not, what Congress intended.

Territories 6-7 (Oct. 7, 2013), *available at* http://www.naic.org/documents/index_health_reform_comments_140501_naic_letter_us_territories_paper_final.pdf.

[42] *Id.* at 9; *see also id.* at 7-11.

CONCLUSION

For the foregoing reasons, the *amici* Economic Scholars respectfully urge that the Court affirm the judgment of the Fourth Circuit.

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